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ABSTRACT

Examples of three emotionally disturbed children whose behavior deteriorated in regular class placements are cited to support the author's contention that the least restrictive environment principle may err in the direction of underserving and underprotecting handicapped children. Also questioned is the violation of individual differences by legislation such as P.L. 94-142, the Education for All Handicapped Children, if normalcy is the espoused goal. (CL)

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BEYOND THE EARLY IDENTIFICATION AND TREATMENT OF THE YOUNG CHILD: THE CHRONIC CHILD PATIENT

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These times of great change appear to have made for upheavals within the institutions of psychiatry and education that suggest movement away from the more traditional, formal notions of treatment. The long time psychiatric concern with prevention and early idenfification will soon be paralleled across the country by "Child Find" programs, based in schools and staffed largely by lay volunteers. A similar traditional concern with the benefits to be derived from early intervention will soon be paralleled by pre-school special education classes in schools. At the same time, various forms of child psychiatric treatment have come to be viewed negatively in favor of notions of "mainstreaming" and "least restrictive" forms of help.[1] Where more formal kinds of treatment are viewed as necessary for children, third party payers, in their evermore powerful voices, cry for quick cures and rapid returns to normalcy. In sometimes better and sometimes worse ways, a pendulum seems to be swinging toward the normalization of behaviorally disturbed children and away from specialized, "clinical" forms of help for them. This paper attempts to call attention to those seriously handicapped children for whom normalization is difficult and complex, for whom simple mainstreaming is inappropriate, if not destructive.

Traditional multi-disciplinary child psychiatric teams tend not to work in particularly quick or efficient ways. Their slow, careful methods may

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[1] "Beyond the clear belief that the regular class is preferred to any other educational alternative, an operational definition of least restrictive environment has yet to be provided. However, what is clear now is that evidence must be provided to justify the placement of a handicapped learner in any alternative other than the regular class". (MacMillan & Semmel, 1977, p.2).

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reflect a recognition of the subtlety and complexity of the problems of children and their families. Certainly all traditional forms of psychiatric help for children have been based in an appreciation of the unique clock that governs the growth and development of different children. In contrast to this long standing respect for history and tempo, some more recent helping techniques, such as behavior modification and psychotropic drugs, have promised rapid, simple change. Schools would seem to have been quick to accept the promise of ahistorical, easily administered, symptom-eliminating techniques, viewing them happily as means of controlling behaviorally difficult students. So too, the promise of social learning techniques (Bandura, 1973) would seem to have prompted faith in the curative powers of "modeling". It would seem to be the promise of these more recent developments that has served as a basis for the belief, and soon-to-be educational policy, that seeks to normalize behaviorally disturbed children by means of education in a normal school setting. In contrast to the slow and delicate methods of traditional efforts at helping a child past a developmental crisis or the still more time consuming methods of coping with developmental deficits, vaguely defined notions of mainstreaming are viewed by some as promising a brave, new egalitarian world of normalcy for all (Rhodes, 1977).

These revolutionary changes (Abeson & Zettel, 1975) are meant to be largely in effect by September, 1978 according to the dictates of PL 94-142, the Education For All Handicapped Children Act of 1975. The law would seem to have had its legal origins in a number of civil rights cases tried in the 1960's that were prompted by the practices of special education classes for

the mildly retarded, the labelling that they entailed and the large numbers of ethnic and racial minority children assigned to them. These court decisions, along with major challenges to the institutions of education and psychiatry in the sixties (Illich, 1971, Szasz, 1967), would seem to have prompted the enormous changes in the education of all handicapped children. Many of the provisions of PL 94-142 were proposed by Dunn(1968) and the concept of least restrictive environment was first advanced by Reynolds(1961).

The civil rights origin of PL 94-142 is an ironic one in that the law may be viewed as restricting the rights of children to be different or to have special needs. The ideal of E Pluribus Unum would seem to have been taken to mean that differences in condition and need are to be denied in favor of uniform educational services. PL 94-142 requires that children be placed in a normal school setting whatever their handicap, even though it has been argued, for example, that mainstreaming is appropriate for only one out of ten deaf children (Greenberg & Doolittle, 1977). The law does permit more protective school settings for children with exceptional need but "evidence must be provided to justify placement of a handicapped learner in any alternative other than the regular class" (MacMillan & Semmel, 1977, p. 2). Similarly, in keeping with Reynolds' initial articulation of least restrictive environment, handicapped children are to be in special settings no longer than necessary, returning to regular classes as soon as improvement permits. Thus, one would expect the seriously behaviorally disturbed child with needs for long time help to receive a thin rehabilitative diet and that even this would be in danger of coming to an end with the first signs of improvement.

Some of the difficulties that are likely to accompany an emphasis on mainstreaming are suggested by the experiences of the more seriously behaviorally disturbed children who began their educational careers at the Charles Bradley Pre-School Program. The Program, an arm of the Emma Pendleton Bradley Hospital, a psychiatric hospital for children located in Riverside, Rhode Island, has been providing diagnostic and treatment services to pre-school aged children for seventeen years. The young, behaviorally disturbed children referred to the Program are evaluated over a two-morning period, being seen by child psychiatrist, psychologist and teacher on one morning while the child's parents are interviewed by a psychiatric social worker, meeting with a pediatrician-neurologist, speech and language therapist and occupational therapist on another. Children who appear to be appropriate for the treatment offerings of the Program are admitted to one of its six therapeutic nursery school groups. The groups tend to be small, being made up of four or five children, who are worked with by two teachers, one of whom is certified in special education of the emotionally disturbed child. The services of the members of the diagnostic team are available to the children as needed in the form of individual psychotherapy, speech and language therapy, fine motor training, or the like. Parents are required to participate in the children's treatment through one of the individual or group forms offered.

Amy C. who is now 14 years old was referred to the Program when she was 5 and having difficulty adjusting to a normal kindergarten class. At that time, her parents described her as having three cycles of behavior: 1) withdrawal in her morning school situation, 2) aggressive, destructive behavior on return home and 3) "high, silly moods after dinner at night". When not

withdrawn she was said to be aggressive and destructive and to have tantrums. She was also said to be given to bizarre behavior, particularly in public. Shortly before this time, Amy was said to be obsessed with her vagina which she felt was turning black, and was constantly peering at herself to determine her color. There had also been a problem of retaining bowel movements for long periods of time. On returning from school, she would plague her mother with unreasonable, illogical questions and demands and would tantrum should her mother refuse to comply. Amy also refused to go to sleep unless everyone else in the household was in bed as well and so established a 9 o'clock bedtime for the entire family. In the course of the evaluation that took place at this time, Amy impressed her six examiners as an anxious, withdrawn, unrelating girl who was selectively mute and bizarre.

At the start of her three year stay in the Program, Amy cried a great deal and often talked to her mother who was not present, typically doing so in high pitched tones. She also exhibited a good deal of bizarre behavior, for example, grabbing the air, suddenly getting up and running in and out of a room, smelling everything within reach and the like. Gradually, she became much more relaxed and came to exhibit far fewer bizarre mannerisms but continued to be an attention seeking child. For a long time she remained on the periphery of her group and had great difficulty relating to children and adults. Gradually both in her group and in individual therapy she grew more communicative and made some feeble efforts at expressing her feelings. During this time her mother attended a mothers' psychotherapy group that met weekly and her parents attended family conferences once each month. While the C. family was a troubled, complex one both parents came to cope with Amy better and to feel that their family situation had eased

considerably. By the end of Amy's stay in the Program she was still a rather remote, occasionally bizarre girl but she was much improved and finally came to be able to relate to adults with some warmth. She made progress in the academic area as well but her learning always seemed to take place on a rather concrete level and her cognitive shortcomings remained evident to the end of her stay.

Amy was 8½ when she was discharged from the Pre-School Program into a self-contained special education classroom in her local community. She did well in that protected setting, progressing academically and presenting tolerable problems at home. The next year, however, she was placed in a regular classroom and with this she encountered great difficulty in getting along with other children. They teased and picked on her, referring to her as "the crazy C. girl". One is tempted to agree with her mother in feeling that Amy was "thrust out too soon". Amy's difficulties in a normal school setting became worse and the C's sought help at the Bradley Child Guidance Clinic. There, despite intensive work with Amy and her family, she again grew more shy and withdrawn and was totally lacking in playmates. She resumed her wars with her mother by hurling obscenities at her. She again became obsessed with elimination and began once more to withhold. She started eating with her hands and grew fearful that she was going to be poisoned, by toothpaste or by getting soap in her mouth. When things reached these dire proportions, Amy was referred to the Bradley Inpatient Service. Amy was hospitalized for fifteen months and once again received intensive treatment. Once again, Amy grew better. She stopped hurling obscenities, she ate reasonably, her fear of poisoning left and she generally grew less bizarre and more relating. She was able to manage home visits and generally came to function

on a much more acceptable level. Gradually, with a good deal of preparation and support, Amy was reintroduced to her family and to a private school setting. When last heard from she was making an acceptable adjustment.

In retrospect, it would seem that things might have gone better for Amy and her family. The girl was fortunate enough to receive a great deal of help relatively early and responded to it well for a child who was so disturbed. She apparently grew strong enough to do well, behaviorally and academically, in a protected school setting, but this unfortunately prompted her being mainstreamed. The girl was obviously unable to cope with demands of a normal school environment and the system was apparently not flexible enough to provide her with the greater protection she needed. At age 12 Amy was again able to use the special people and arrangements of a most restricted setting to recoup and grow. She does, however, promise to remain a chronic patient, one whose ability to participate in the mainstream on its terms is likely to be limited.

Too many of the Program's former participants appeared to have experienced similar fates. Peter is now 16 years old and was referred to the Program at 3 years of age with a diagnosis of autism. He was said by his parents to have presented a life long picture of indifference and unresponsiveness accept for his penchant for indiscriminate temper tantrums. At the time of his referral he did not speak or communicate in other ways and demonstrated no interest in play or relationship. Whenever possible he devoted his time to record players and classical music. Just prior to his entering the Program his heightened tantruming and parental exhaustion prompted his pediatrician to hospitalize him for "respite" purposes.

Peter spent four years in the Pre-School, participating in a program much like Amy's. His mother was in a mothers' group for two of those years, went on to a mixed group for one year, while his father was seen individually for those three years. During Peter's final year in the Program his parents were seen jointly on a monthly basis. Peter made a great deal of progress during his long stay, far more than his diagnosis would have led one to expect. Described as withdrawn, obstinate, tantrumy and unspeaking at the outset, he made some minimal efforts at speaking and relating during the first year. He gradually came to engage in pre-school kinds of activities, learned quickly as long as letters and numbers were presented to him in concrete ways and came to seek out teachers for support and affection. Peter's efforts at relating remained awkward throughout but people came to take on ever more meaning and importance to him. He performed reasonably and well as long as he was heavily structured and firm limits were maintained for him but he was still given to anxious, highly personalized behavior if left to his own devices. Peter left the Program for a special education class placement fully verbal and ready to cope with reading and arithmetic on a second grade level.

Things went reasonably well for Peter for the four years of his special class placement. His ways were odd, relating was not easy for him, he was given to exaggerated fears and life with him at home was not always easy. By his 13th year, he was viewed as being too old for his protected class and he was mainstreamed on to a larger Junior High school setting. It was quickly apparent that he could not cope with the new demands made of him and his behavior deteriorated rapidly. We began to receive requests for information from varieties of diagnostic and treatment centers, including the one to which

he was admitted when he was 14. When last heard from, late last year, Peter was being considered for admission to a psychiatric hospital in the Boston area. While Peter had been able to make something of an adjustment for himself over a ten year period with a good deal of school and home support, he was obviously unable to survive mainstreaming.

Andy's story is somewhat similar. He is now 12 years of age and was referred to the Program when he was 3½. Like Amy and Peter, he appeared to be a seriously disturbed child at the time of referral: unhappy about separating from his mother, selectively mute, never speaking more than a word or two, without interest in toys or playmates, a toe-walker who often flapped his arms and was largely inattentive and quick to tantrum, particularly in terms of some of his more bizarre concerns and rituals. While Andy participated in his group and was seen individually in psychotherapy, his mother took part in therapy groups and both parents were seen monthly in family conferences. The boy responded well to treatment and was soon quite verbal and more relating. By the time he left the Program he was academically quite able, was using grammatically correct speech and behaving reasonably at home although he was never truly at ease socially and was given to varieties of highly personalized fears and behaviors.

Andy survived his first year in a public school special education class, even though he and his teacher were not at ease with one another. He did well enough academically the next year but he was growing ever more fearful and withdrawn and more intolerant of any sort of change in his environment. With Andy doing no better the next year, his parents sought his admission to Bradley's Day Hospital Program. Now in his third year at Day Hospital, Andy seems to have made his way back to his most reasonable level of functioning. He

remains too quick to feel intruded upon by others but he is more realistic and able in his daily life. He is compulsive in his ways and it may be this that makes some of his more bizarre concerns and rituals less apparent.

Andy is about to be returned to a less restricted setting. It is planned to phase him back gradually with a great deal of care and support. Hopefully it will be possible for his new school setting to appreciate the special ways and needs that promise to be his for a long time to come and to resist urges to normalize him quickly.

Amy, Peter and Andy have not been good candidates for mainstreaming. The three have experienced extreme developmental difficulties from the very beginning of their lives. Each has found communication to be difficult, certainly as young children, but even now that they are thoroughly verbal they seem less than comfortable with language. Relating to others has always proven to be difficult for them and each is even now relatively remote and withdrawn and uneasy with people. All of the children have mastered the basics of an elementary school education but despite their very good memories each has seemed most comfortable with the concrete and to not live well with abstractions. Clearly children with this array of difficulties are not helped by mainstreaming. In fact, an insistence that they adapt to normal school settings has proven to be be a destructive experience for each and promises always to be so for them.

The concept of least restrictive environment would seem all but to require such negative placements. In that the goal of mainstreaming is to place the handicapped child in the most normal of environments, errors in placement will be largely in the direction of underserving and underprotecting. Just as Amy, as a disturbed 5-year old, was "overplaced" by her parents

in a normal kindergarten, so it seems likely that many handicapped children will be required to endure the strains and damages of failure before receiving the special array of help and support that they need. At the beginning of a child's school career, and again with periods of progress, the thrust of least restrictive placement will be toward trials of normalcy. Trials take time, short periods by some standards but easily twenty percent of the total life span of some young children. Six months or a year may be required for a reasonable trial that may also span an important developmental era in the life of a young child.

Mainstreaming proved to be difficult for the three children considered here, despite the fact that each responded well to early treatment and left the Program with vastly improved coping abilities. Interestingly, the children had prospered in a setting that gave relatively low priority to their education and the normalcy of their school environment. While they were exposed to conventional pre-school activities by special education teachers, their treatment entailed a comprehensive set of integrated services provided by a team of disciplines and was focused on the needs of the children and their families far beyond their education. The services were offered in an environment designed to counter the children's short attention spans, limited tolerance of frustration, distress in the face of change, and the like, designed by individuals who were sensitive and sympathetic to varieties of unusual need. Normalcy of setting seemed to have little relevance to children struggling with intimidating relationships or overpowering tantrums.

Finally, the process by which political and civil rights issues appropriate to some groups of children became transformed into educational and treatment policy for "all handicapped children" is difficult to understand.

It is not difficult to view the exclusion of handicapped children from education on the basis of their handicaps as a rights issue. It is also apparent that the unnecessary use of special education classes for large numbers of minority group children entails unequal treatment. However, the political advantages that accrue to a deaf child, for example, by the insistence that he be the only non-hearing child in a large classroom of hearing children and a harried teacher are less than apparent. It would seem that the deaf child's civil rights and his educational and emotional needs would be better served in a school setting geared to his special needs and in which his fellow students and teachers understood and were sensitive to the problems of non-hearing. While our political system holds that all children are born equally eligible for the rights and privileges of citizenship, it cannot be argued that all children are born equally able or with equal needs. Our nation is proud of its melting pot tradition but the pot has never been meant to be fired by the violation of the individual differences that make each child unique. The civil and human rights of some children require that they not be forced to be normal, that they be accepted and supported as the different people that they are.

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